Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WILLIAM J KOWALSKI DC
12655 WOODFOREST BOULEVARD
HOUSTON TX 77015

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-10-4187-01

MFDR Date Received

MAY 20, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "-bills sent carrier never considered carrier billed in accordance to guidelines never paid never audited - carrier billed no EOB no pay required report TDI 73"

Amount in Dispute: $2,205.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier is in the process of re-auditing the bills for payment."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 29, 2009 through October 23, 2009	Physical Therapy Service, Office Visits and Work Status Reports	$2,205.00	$2,205.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement for professional services.
3. 28 Texas Administrative Code §129.5 sets out the guidelines filing for Work Status Reports.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Neither party submitted EOBs for all other dates of service except October 23, 2009.
   - 45 – Charges exceed your contract/legislated fee arrangement.
   - 1IQ – Any network reduction is in accordance with the network referenced above.
   - 1VX – FHN contract status indicator 11 – Negotiated or other pricing. (111-011)

Issues

1. Did the request received payment from the insurance carrier?
2. Did the requestor have a contractual agreement with the insurance carrier?
3. Is the requestor entitled to reimbursement?

Findings

1. According to the insurance carrier's response that they are re-auditing the bills for payment, the Division has contacted the requestor numerous times to establish if reimbursement was received. At this time no reimbursement has been received after the Medical Fee Dispute Resolution filing date. As a result the disputed services will be reviewed in accordance with Division rules and the Labor Code.
2. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges exceed your contract/legislated fee arrangement"; 1IQ – "Any network reduction is in accordance with the network referenced above"; and 1VX – "FHN contract status indicator 11 – Negotiated or other pricing. (111-011)." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reasons are not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

   In accordance with 28 Texas Administrative Code §129.5(d) "the doctor shall file a Work Status Report (2) when the employee experiences a change in work status or a substantial change in activity restrictions. At 28 Texas Administrative Code §129.5(i) notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section... Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT Code '99080' with modifier '73' shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section…" Review of the complete Work Status Reports submitted by the requestor finds that Work Status Report for date of service July 27, 2009 does not show any change in the work status as the report filed June 25, 2009. For this reason reimbursement is recommended for the June 25, 2009 date of service; reimbursement is not recommended for the Work Status Report billed July 27, 2009. The Work Status Report dated October 2, 2009 shows a change of work status as the employee is allowed to return to work as of October 2, 2009 with restrictions. The Work Status Report dated October 23, 2009 shows a change of work status as the employee is allowed to return to work as of October 23, 2009 without restrictions. Therefore reimbursement is as follows:

   - CPT Code 99080-73 – 4 Work Status Reports billed at $15.00 per report = $60.00 - $15.00 (carrier payment) = $45.00

   28 Texas Administrative Code §134.203(c) states, in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is… (2) Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The MAR for the payable services may be calculated by (2008 TDI-DWC MEDICARE CONVERSION FACTOR) x Facility Price = MAR.

   - CPT Code 97110 – (53.68 ÷ 36.0666) x $42.39 x 28 Units = $1,186.88
   - CPT Code G0283 – (53.68 ÷ 36.0666) x $17.41 x 11 Units = $191.55
   - CPT Code 99212 – (53.68 ÷ 36.0666) x $37.50 x 8 Units = $446.51 - $46.88 (insurance carrier payment) = $399.63
   - CPT Code 99214 – (53.68 ÷ 36.0666) x $138.74 x 1 Units = $138.74
   - CPT Code 97022 – (53.68 ÷ 36.0666) x $25.86 x 8 Units = $206.94
   - CPT Code 97032 – (53.68 ÷ 36.0666) x $16.40 x 3 Units = $73.23
   - CPT Code 97116 – (53.68 ÷ 36.0666) x $24.74 x 1 Unit = $36.82

3. Review of the submitted documentation finds that the requestor is due reimbursement for the services rendered. Amount in dispute, per the table of disputed services, is less than MAR, therefore $2,205.00 is ordered.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $2,205.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,205.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		May 9, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.